

Add. inf. on cause of death from  
letter from Dr. Covalesky 11-7-47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08958

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **CECIL**  
City or town..... **PERRY POINT, MD.**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **10 days**  
Hospital, institution, or street address where death occurred:  
**VAH, Perry Point, Md.**  
How long in hospital or institution? **120 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... **North Carolina** County.....  
City or town..... **Asheville**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **51 Carroll Avenue**  
(If rural, give LOCATION)  
2. (a) If veteran, name war..... **World War I** ✓

3. (a) FULL NAME

**MOSES BLANCHARD**

3. (b) Social Security Number

4. Sex **M** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **Divorced**

6. (b) Name of husband or wife **Unknown**

7. Birth date of deceased (mo., day, yr.) **May 2, 1893** 6. (c) If alive, give age..... years

8. AGE: Years **54** Months **5** Days **23** If less than one day..... hrs. .... min.

9. Birthplace..... **Asheville, N.C.**  
(Town, county, and state)

10. Usual occupation..... **Ball Park Attendant**

11. Industry or business

12. Name..... **Unknown**

13. Birthplace..... **Unknown**

14. Maiden name..... **Unknown**

15. Birthplace..... **Unknown**

16. Informant..... **Hospital Records**

Address..... **VAH, Perry Point, Md.**

17. **Removal** Date thereof..... **10-26-47**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Unknown**

Location.....

18. Funeral director..... **Pennington & Pen**

Address..... **Havre de Grace, Md.**

19. **Oct 26** 19. **47** **June E. Blough**  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 25** 19. **47** at **6:30 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**October 15** 19. **47** to **October 25** 19. **47**  
and that I last saw him alive on **October 25** 19. **47**

Immediate cause of death..... DURATION

**Uremia** **5 days**

Due to..... **due to Tabetic bladder** **3 mos.**

**due to Central nervous system**

Due to..... **syphilis** Duration over **10 years**

Other conditions..... **Possible pneumonia-broncho** **2 days**

**Tabetic bladder** **107** **Unknown**

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... **No autopsy**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... **V. J. COVALESKY, M.D., Act. Clin. Director**

Address..... **VAH, Perry Point, Md.** Date signed..... **10-24-47**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GRAND NATIONAL COUNCIL

200

GRAND NATIONAL COUNCIL

RECEIVED

OCT 28 1947

BUREAU 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08959 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Maryland  
 (if outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 mos. 13 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Cecil  
 City or town Port Deposit  
 (if outside city or town limits, write RURAL and give nearest town)  
 Street No. RT #1, Box #16  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-II

## 3. (a) FULL NAME

BROWN, Harry L.

## 3. (b) Social Security Number

4. Sex M 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Jan. 30, 1923  
 8. AGE: Years Months Days If less than one day  
24 9 24 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rowlandsville, Md.  
 (Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

12. Name Raymond J. Brown, Sr.  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant Hospital Records  
 Address

17. Burial Date thereof Oct. 30, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Zoar Cemetery  
 Location Conowingo, Md.

18. Funeral director J. EARL TYSON  
 Address Rising Sun, Maryland

19. Oct - 27 19 47 Irene E. Humphrey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 19 47 at 7:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 19 47, to Oct. 27 19 47, and that I last saw him alive on October 27 19 47.

Immediate cause of death Uremia DURATION 3 months

Due to Chronic glomerule nephritis Approx. 1 yr.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 5 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. COVALESKY M.D. Acting Clin. Director  
VAH, Perry Point, Md. Date signed 10-27-47

**RECEIVED**

OCT 29 1947

**BUREAU**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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08966 94

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH: Cecil  
County.....  
City or town..... North East Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 yrs  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md..... County..... Cecil  
City or town..... North East Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Arrie H. Burns

### 3. (b) Social Security Number

4. Sex..... Female  
5. Color or race..... White  
6. (a) Single, married, widowed, or divorced..... married  
6. (b) Name of husband or wife..... Harry Burns  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... April 15 1861  
8. AGE: Years..... 76 Months..... 5 Days..... 18 If less than one day..... hrs..... min.....  
9. Birthplace..... Cecil Co. Md.  
(Town, county, and state)  
10. Usual occupation..... none  
11. Industry or business.....

12. Name..... William Howland  
13. Birthplace..... Maryland  
14. Maiden name..... Mary Matthews  
15. Birthplace..... Maryland

16. Informant..... Harry Burns  
Address..... North East P.O. Box  
Burns

17. (Burial, cremation, or removal, Which?)..... Burial Date thereof..... Oct 5, 1947  
(month) (day) (year)  
Cemetery or crematory..... Methodist  
Location..... Bay View Md

18. Funeral director..... Joseph P. Evans  
Address..... North East

19. 10 - 6 19 47 Lida E. Owens  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3 Oct. 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Oct. 1947 and that I last saw her alive on 3 Oct. 1947

Immediate cause of death..... Cerebral Hemorrhage  
DURATION..... 1 Hour  
Due to..... Generalized Arteriosclerosis 25 years  
Due to..... Essential Hypertension 25 years

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) .....  
Means of injury..... Injured at work? .....

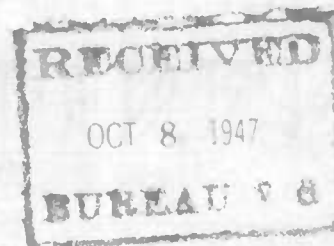
23. SIGNATURE..... Klaus H. Huebner M.D.  
North East, Md M. D. or other  
Address..... North East, Md Date signed 4 Oct. 47

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08961 96

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Perryville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Cecil  
 City or town..... Perryville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Anna Burroughs

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Ormond R. Burroughs  
 B.(c) If alive, give age..... 29 years  
 7. Birth date of deceased (mo., day, yr.)..... June 9, 1919  
 8. AGE: Years..... 28 Months..... 4 Days..... 22 If less than one day..... hrs. .... min.

9. Birthplace..... Perryville, Cecil Co., Md.  
 (Town, county, and state)  
 10. Usual occupation..... House Wife

## 11. Industry or business

FATHER 12. Name..... George L. Alexander  
 13. Birthplace..... Perryville, Md.  
 MOTHER 14. Maiden name..... Edith Patterson  
 15. Birthplace..... Perryville, Md.

16. Informant..... Ormond R. Burroughs Jr.  
 Address..... Perryville, Md

17. Burial..... Nov. 3, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Asbury

Location..... Port Deposit, Md. Rural

18. Funeral director..... Ed A. Patterson & Son  
 Address..... Perryville, Md.

19. Nov 1 19 47 Jane E. Doughty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 31 19 47 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1st 19 46 to October 31 19 47  
 and that I last saw h..... alive on October 31 19 47

Immediate cause of death..... Acute infection of heart  
 DURATION..... 1 day

Due to..... Chronic valvular heart disease  
 DURATION..... 20

Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... J. F. Magrath  
 Address..... Perryville Md. M. D. or other.....  
 Date signed..... Nov 1, 1947

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CERTIFICATE OF DEATH

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NOV 5 1947  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

C8962

96

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

County.....Preryl  
 City or town.....Perryville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long la above place of death?.....at work  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Ind. County.....Preryl  
 City or town.....Perryville Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Bedford Roe Burrows

## 3. (b) Social Security Number

4. Sex.....M 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married  
 6.(b) Name of husband or wife.....Nicholas Francis Burrows 8.(c) If alive, give age.....30 years  
 7. Birth date of deceased (mo., day, yr.).....Sept 4 1910

8. AGE: Years.....37 Months.....1 Days.....10 If less than one day.....hrs.....min.

9. Birthplace.....Perryville Ind.  
 (Town, county, and state)  
Rigger

10. Usual occupation.....Rigger

11. Industry or business.....

FATHER 12. Name.....Adner R Burrows  
 13. Birthplace.....Perryville Ind.

MOTHER 14. Maiden name.....Mary E Redgrave  
 15. Birthplace.....Perryville Ind.

16. Informant.....Thomas Burrows  
 Address.....Perryville Ind.

17.....Burial Date thereof.....Oct 17 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....Hopewell

Location.....East Hospital Ind. Rural

18. Funeral director.....W. A. Patterson & Son  
 Address.....Perryville, Ind.

19.....Oct 17 1947.....Dune & Dougherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct 14 1947 at 3:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19..... to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....Compound

Due to.....Fracture of skull

Due to.....with loss of

Due to.....brain tissue

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide.....Accident Date of.....10-14-47

Where did injury occur?.....Perryville Ind  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....Industry  
 Means of injury.....Falls 5 feet Injured at work?.....yes

23. SIGNATURE.....Bill Jackson  
 M. D. or other.....MD

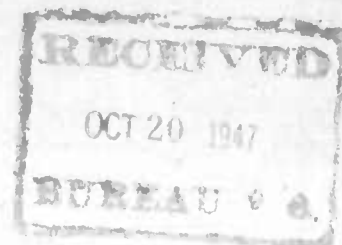
Address.....Crisp Sun Ind Date signed.....10-14-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

08963

## CERTIFICATE OF DEATH

Reg. Dist. No. 80

## 1. PLACE OF DEATH

County Cecil  
 City or town Seaboard Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County Kent  
 City or town Dover  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 226 Columbia Ave  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

John H. Carlin Jr

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Aug. 29 - 1928

8. AGE:

19118

If less than one day

hrs.

min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual occupation

Auto service man

11. Industry or business

FATHER

12. Name

John H. Carlin Sr.

13. Birthplace

Pa.

MOTHER

14. Maiden name

Enclim Kincaid

15. Birthplace

Virginia

16. Informant

John H. Kincaid

Address

Dover Delaware

17.

(Burial, cremation, or removal, which?)

Burial

Date thereof

10-18-47

Cemetery or crematorium

Lake Side cemetery

Location

Dover Delaware

18. Funeral director

J. Fisher Daniels

Address

Middletown Del

19.

(Date rec'd by registrar)

Oct 1647Mrs. Harold W. Chepy

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1947 at 1240 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Cornpound fracture of skull.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/16-47Where did injury occur Seaboard Cecil Md. (City or town) (County) (State)Injured at home, farm, industry, public place, (where?) Road at 22Means of injury Automobile Injured at work? no

23. SIGNATURE

Ree Dodeon MD Medical Examiner for Cecil CountyRee Dodeon MD M. D. or other 10/16-47 Date signed

RECEIVED

OCT 18 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The subject age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

94a

08964

96

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Port Deposit  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 50 Yrs.  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Cecil  
 City or town... Port Deposit  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 50 S. Main  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Nettie M. Creamer

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 8.(b) Name of husband or wife... Harry C. Creamer  
 7. Birth date of deceased (mo., day, yr.) April 13, 1861  
 8. AGE: Years 86 Months 5 Days 25 If less than one day  
 ..... hrs. .... min.

9. Birthplace... Baltimore, Md.  
 (Town, county, and estate)  
 10. Usual occupation... House Wife

## 11. Industry or business

12. Name... John A. Mitchell  
 13. Birthplace... Harford Co., Md.  
 14. Maiden name... Addie White  
 15. Birthplace... Cecil Co., Md.

16. Informant... Mrs. A. James Roe  
 Address... Port Deposit, Md.

17. Burial Date thereof... Oct. 11, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Hopewell  
 Location... Port Deposit, Md. Rural

18. Funeral director... L. A. Patterson & Son  
 Address... Ferryville, Ind.

19. Oct. 11, 1947 Dr. E. Daugherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... October - 8 19 47 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 10 19 47 to Oct 8 19 47  
 and that I last saw h... alive on Oct 8 19 47

Immediate cause of death..... DURATION

Coronary Occlusion - 5 mts.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... E. Benbow, M.D.

Address... Port Deposit, Md. Date signed 10/9/47

CERTIFICATE OF DEATH

RECEIVED  
OCT 13 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08965

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... CECIL  
 City or town..... PERRY POINT, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 18 yrs. 11 mos. 12 das.  
 Hospital, institution, or street address where death occurred:  
VAH, Perry Point, Maryland  
 How long in hospital or institution?..... 28 yrs. 7 mos. 9 das.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... New York County..... Richmond  
 City or town..... New Brighton, Staten Island  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
World War I  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

ROCCO DANZIG

## 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... White  
 6. (a) Single, married, widowed, or divorced..... Unknown  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... 1893  
 8. AGE: Years..... 54 Months..... Unkwn Days..... Unkwn It less than one day..... hrs. .... min.  
 9. Birthplace..... Italy  
 (Town, county, and state)  
 10. Usual occupation..... Laborer  
 11. Industry or business.....  
 12. Name..... Unknown - Deceased  
 13. Birthplace..... Italy  
 14. Maiden name..... Unknown - Deceased  
 15. Birthplace..... Italy

16. Informant..... Hospital Records  
 Address..... VAH, Perry Point, Maryland  
 17. Removal Date thereof..... 10-2-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... St. Peters Cemetery  
 Location..... Staten Island, New York  
 18. Funeral director..... Bennington / Ben  
 Address..... Havre de Grace, Maryland  
 19. Oct - 2 19 47 James E. Daugherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 1 19 47 at 3 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 19 19 28 to October 1 19 47  
 and that I last saw him alive on October 1 19 47

Immediate cause of death.....  
Tuberculosis, pulmonary, chronic,  
far advanced, active  
 DURATION  
over 20  
years

Due to.....  
 Due to.....  
 Other conditions..... Dementia Praecox,  
Catatonic Type  
 (Include pregnancy within 3 months of death)  
 29 years.

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... A. E. Trollinger  
A. E. TROLLINGER, M. D., Clin. Director  
VAH, Perry Point, Md.  
 Address..... Date signed..... 10-2-47

RECEIVED

OCT 4 1947

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

57d

08966

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... EssexCity or town... Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Clinton Hospital

How long in hospital or institution?

3 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ind. County... EssexCity or town... Conventown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Essex road P.O. 3

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Lawnie Egner

## 3.(b) Social Security Number

4. Sex F. 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Joren T. Egner8.(c) If alive, give age 57 years

7. Birth date of

deceased (mo., day, yr.)

May 4 1890

8. AGE:

Years

Months

Day

If less than one day

57523

hrs.

mo.

9. Birthplace

Conventown Ind.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

18. Cemetery or crematory

Location

19. Funeral director

Address

20. Date rec'd by registrar

19. 47

21. Registrar

22. Address

23. Date signed

24. Signature

25. Date signed

26. Signature

27. Date signed

28. Signature

29. Date signed

30. Signature

31. Date signed

32. Signature

33. Date signed

34. Signature

35. Date signed

36. Signature

37. Date signed

38. Signature

39. Date signed

40. Signature

41. Date signed

42. Signature

43. Date signed

44. Signature

45. Date signed

46. Signature

47. Date signed

48. Signature

49. Date signed

50. Signature

51. Date signed

52. Signature

53. Date signed

54. Signature

55. Date signed

56. Signature

57. Date signed

58. Signature

59. Date signed

60. Signature

61. Date signed

62. Signature

63. Date signed

64. Signature

65. Date signed

66. Signature

67. Date signed

68. Signature

69. Date signed

70. Signature

71. Date signed

72. Signature

73. Date signed

74. Signature

75. Date signed

76. Signature

77. Date signed

78. Signature

79. Date signed

80. Signature

81. Date signed

82. Signature

83. Date signed

84. Signature

85. Date signed

86. Signature

87. Date signed

88. Signature

89. Date signed

90. Signature

91. Date signed

92. Signature

93. Date signed

94. Signature

95. Date signed

96. Signature

97. Date signed

98. Signature

99. Date signed

100. Signature

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Tumor of brain

DURATION

Due to

Malignancy unknown

Due to

11/27/47 9:25

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Alfred Dodson M.D. Essex23. Signature EssexAddress Essex Ind. Date signed 10/27-47

RECEIVED  
OCT 29 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08967

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County CECIL  
 City or town PERRY POINT, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs. 8 mos. 23 das.  
 Hospital, institution, or street address where death occurred:  
VAH, Perry Point, Md.  
 How long in hospital or institution? 28 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MASSACHUSETTS County Hampden  
 City or town Holyoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 342 Main Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War I ✓

## 3. (a) FULL NAME

JOHN B. GIGUERE

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife ---7. Birth date of deceased (mo., day, yr.) August 27, 1888

8. AGE: Years 59 Months 1 Days 8 It less than one day --- hrs. --- min. ---

9. Birthplace Fairview, Massachusetts  
(Town, county, and state)10. Usual occupation Printer11. Industry or business ---12. Name Unknown - Deceased13. Birthplace Unknown14. Maiden name Unknown - Deceased15. Birthplace Unknown16. Informant Hospital RecordsAddress VAH, Perry Point, Md.17. Removal Date thereof October 9, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Burroughs & SonAddress Havre de Grace, Md.19. Oct - 9 19 47 Irene E. Daugherty  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 19 47 at 4:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 12 19 45 to October 5 19 47  
 and that I last saw him alive on October 5 19 47

Immediate cause of death Arteriosclerotic coronary heart disease  
 DURATION Unknwn

Due to ---

Other conditions Arteriosclerosis, generalized  
 (Include pregnancy within 3 months of death)  
 DURATION Unknwn

Major findings of operations ---Date of op. ---Autopsy results Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? ---

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE A. E. Trollinger, M.D., Clin. DirectorAddress VAH, Perry Point, Md. Date signed 10-7-47

RECEIVED  
OCT 13 1947  
B-1241 9 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

107

08968

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County **CECIL**  
 City or town **PERRY POINT, MARYLAND**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **2 years 11 mos. 3 das.**  
 Hospital, institution, or street address where death occurred:  
**VAH, Perry Point, Md.**  
 How long in hospital or institution? **29 years**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State **MARYLAND** County **BALTIMORE**  
 City or town **BALTIMORE**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **3530 Reisterstown Road**  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war **WW-I**

## 3. (a) FULL NAME

**SOLOMON GOLDSTEIN**

## 3. (b) Social Security Number

4. Sex **M** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **Widowed**  
 6. (b) Name of husband or wife **Syd Spira**  
**Deceased** 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) **March 11, 1894**  
 8. AGE: Years **53** Months **7 mos** Days **10** It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace **Baltimore, Maryland**  
 (Town, county, and state)

10. Usual occupation **Salesman**

11. Industry or business

12. Name **Nathan Goldstein**

13. Birthplace **Russia**

14. Maiden name **SCHERR**

15. Birthplace **RUSSIA**

16. Informant **Hospital Records**

Address **VAH, Perry Point, Md.**

17. **Removal** Date thereof **10-21-47**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Hebrew Friendship Cemetery**

Location **Baltimore, Maryland**

18. Funeral director **Sol. Levinson Bros**

Address **1124 W. North Ave., Baltimore, Md.**

19. **10/21** 19 **47** **Sam S. Dougherty**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **October 21** 19 **47** at **2:40 A.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**November 18** 19 **44**, to **October 21** 19 **47**  
 and that I last saw him alive on **October 21** 19 **47**

Immediate cause of death **Bronchopneumonia** DURATION **2 days**

Due to

Due to

Other conditions **Manic depressive psychosis** **29 years**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **No autopsy**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE **V. J. COVALESKY, M.D., CLIN. DIRECTOR (ACTG)**

Address **VAH, Perry Point, Md.** Date signed **10-21-47**

RECEIVED

OCT 22 1947

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

### 1. PLACE OF DEATH:

County Cecil  
City or town Liberty Grove  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 43 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md. County Cecil  
City or town Liberty Grove  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Blanche Ethel Grist

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Howard Grist  
7. Birth date of deceased (mo., day, yr.) Aug. 26, 1883 6.(c) If alive, give age 64 years  
8. AGE: Years 64 Months 2 Days 4 If less than one day hrs. min.

9. Birthplace Berkeley Harford Co. Md.  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name John Smith  
13. Birthplace md.  
14. Maiden name Sarah Mc Nutt  
15. Birthplace md.

16. Informant Howard Grist  
Address Liberty Grove Md.

17. Burial Date thereof Nov 2 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematorium West Nottingham  
Location Calover Md.

18. Funeral director J. C. Tyson  
Address Rising Sun Md.

19. Not recorded 11-1-47  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1947 at 4:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-10 1946 to 10-30 1947  
and that I last saw him alive on 10-29 1947

Immediate cause of death Cerebral Vascular Accident

Due to Myocarditis Chronic & Hypertensive Cardiovascular disease 10 yrs.  
Due to Hypothyroid 20 yrs.  
Other conditions

(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Michael M.D. M. D. or other  
Address Port Deposit Md. Date signed 11-1-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 5 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *92*

08970

## 1. PLACE OF DEATH:

County *Cecil*  
 City or town *Elkton RD (Fair Hill) Md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *52 yrs*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State *Maryland* County *Cecil*  
 City or town *Elkton Md RD*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *Fair Hill Md*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

*William H Hamilton*

## 3.(b) Social Security Number

*213-05-3990*

4. Sex *Male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *married*  
 8.(b) Name of husband or wife *Reba M Hamilton*  
 7. Birth date of deceased (mo., day, yr.) *March 24 1911* 8.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years *76* Months *6* Days *16* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *West Newton Pa*  
 (Town, county, and state)  
 10. Usual occupation *Plumber*  
 11. Industry or business  
 12. Name *James Hamilton*  
 13. Birthplace *Ireland*  
 14. Maiden name *Priscilla Rollins*  
 15. Birthplace *West Newton Pa*

16. Informant *Mabel Bouchanon*  
 Address *Elkton Md*  
 17. *Burial* Date thereof *Oct 14 1947*  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Sharps Cemetery*  
 Location *Fair Hill Maryland*  
 18. Funeral director *H W Bigner*  
 Address *Elkton Md*

19. *Oct 14 1947* Registrar *J R Frazier*  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH *10 October* 19*47*, at *4:25 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1 October* 19*47*, to *10 October* 19*47*, and that I last saw him alive on *10 October* 19*47*

Immediate cause of death *Heart Failure* DURATION *48 hours*

Due to *Hypertensive cardiovascular disease* Unknown

Due to *Pulmonary (Post)* Unknown

Other conditions *arteriosclerosis* Unknown

(Include pregnancy within 3 months of death)

Major findings of operations *None*

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work?

23. SIGNATURE *George Klein, Jr* M. D. or other *94. D*Address *Elkton, Md.* Date signed *10 Oct 1947*



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08971 92

### 1. PLACE OF DEATH:

County..... Cecil  
City or town..... Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Union Hospital of Cecil County

How long in hospital or institution?

### 3. (a) FULL NAME

Carol Lee Hutchison

4. Sex..... female  
5. Color or race..... white  
6. (a) Single, married, widowed, or divorced..... single

6. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... October 24, 1947

8. AGE: Years..... 2  
Months.....  
Days.....  
If less than one day..... hrs. .... min.

9. Birthplace..... Elkton, Cecil Co., Maryland  
(Town, county, and state)

10. Usual occupation..... Newborn infant

11. Industry or business.....

12. Name..... George Thomas Hutchison

13. Birthplace..... Delaware City, Delaware

14. Maiden name..... Lulu Louise Mc Kelvey

15. Birthplace..... Baltimore County, Md.

16. Informant..... Lulu Hutchison

Address..... 131 Maffett Street

11. Burial..... ELKTON MD

Date thereof..... Oct 27/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Bethel

Location..... Near Chesapeake City, Md

18. Funeral director..... H. W. Lippert

Address..... Elkton, Md

19. Oct 27 19 47

(Date rec'd by registrar)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Cecil

City or town..... Elkton  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 131 Maffett Street  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 24 1947 at 11:15 P.M.

21. I CERTIFY that death occurred as the date above stated; that I attended deceased from Oct. 24 1947 to Oct 26 1947  
and that I last saw him alive on Oct 26 1947

Immediate cause of death..... Erythroblastosis fetalis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... Dr. Ford H. Sprecher

Address..... Elkton, Md

Date signed..... Oct 27

19. Oct 27 19 47

(Date rec'd by registrar)

Registrar

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 29 1947  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

08972

159

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... about 5 hours  
 Hospital, institution, or street address where death occurred:  
 Union Hospital of Cecil Co  
 How long in hospital or institution?..... 5 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Delaware County..... New Castle  
 City or town..... Elsmere Manor Wilmington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 1036 Dover Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

Irene Lynch

## 3. (b) Social Security Number

4. Sex..... female  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... Single

8.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... If less than one day.....  
 4 hr. 45 Min..... 4 hrs. 45 min.

9. Birthplace..... Union Hospital Cecil  
(Town, county, and state)

10. Usual occupation..... Infant

11. Industry or business.....

12. Name..... Alvin Crisfield Lynch

13. Birthplace..... Middletown Delaware

14. Maiden name..... Mary Coulter Speakman

15. Birthplace..... Cochranville, Pa.

16. Informant..... Alvin C. Lynch

Address..... Elsmere Manor, Wilm.

17. Burial..... Date thereof..... Oct 27/47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Elkton

Location..... Elkton, Md.

18. Funeral director..... H.W. Pippin

Address..... Elkton, Md.

19. Oct 27 19 47 F.R. J. Ragan  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 25 19 47 at 9<sup>PM</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25 19 47 to Oct. 25 19 47 and that I last saw him alive on Oct. 25 19 47

Immediate cause of death.....

Drenth - (2.8 wk.)

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?.....

Means of injury..... Injured at work?

23. SIGNATURE..... Dr. David W. Speaker

M. D. or other

Address..... Elkton, Maryland Date signed 10/26/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 29 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08973

Reg. Dist. No. 95

## 1. PLACE OF DEATH:

County CecilCity or town Lombard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Many yearsHospital, institution, or street address where death occurred: At home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Nottingham Penna

(If outside city or town limits, write RURAL and give nearest town)

Street No. Lombard Maryland

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Elphonsa Kirk Martindelle

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Walter Martindelle7. Birth date of deceased (mo., day, yr.) Jan 19 18746. (c) If alive, give age 75 years

8. AGE: Years Months Days It less than one day

73

hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William B. Kirk13. Birthplace Maryland14. Maiden name Lillie Ewing15. Birthplace Maryland16. Informant Walter MartindelleAddress Nottingham R.D.17. Burial Date thereof Oct, 11-1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Bank Calvert Md,Location Near Rising Sun.18. Funeral director J. E. TysonAddress Rising Sun Md19. Oct-8-47 Nottingham

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 19 47 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 40 to Oct 8 19 47and that I last saw h. ex. alive on October 7 19 47Immediate cause of death Coronary Heart FailureDue to Arteriosclerosis

Due to

Other conditions Intra abdominal valvulopathy with mediastinal metastases

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F.B. Robinson MD

M. D. or other

Address

Date signed

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OCT 9 1947  
BUREAU 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Rural near Elkton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
 R.D. 1  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County... Cecil  
 City or town... Rural near Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... R.D. 1  
 (If rural, give LOCATION)  
 2.(c) If veteran, name war

## 3. (a) FULL NAME

DeVaux McKee

## 3. (b) Social Security Number

121-16-8923

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M Wh Married

6. (b) Name of husband or wife 6. (c) If alive, give age

Bonnie H. McKee 68 years

7. Birth date of deceased (mo., day, yr.)

May 12, 1875

8. AGE: Years Months Days If less than one day

72 5 10 hrs. min.

9. Birthplace (Town, county, and state)

Tenn. Retired

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Cremation Date thereof

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Oct 23 19 47 J.R. Frazer

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 19 47 at 8<sup>00</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 47 to Oct. 22 19 47

and that I last saw him alive on 19

Immediate cause of death

Carcinoma of larynx

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Ca. of larynx

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

Date signed

RETURN TO THE UNITED STATES DEPARTMENT OF JUSTICE

STATE OF TEXAS

DEPARTMENT OF JUSTICE

RECEIVED

OCT 24 1947

BUREAU 6 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

08975

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... CECIL  
 City or town..... PERRY POINT, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 11 mos. 22 das.  
 Hospital, institution, or street address where death occurred:  
VAH, Perry Point, Maryland  
 How long in hospital or institution?..... About 2 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... MARYLAND County..... Montgomery  
 City or town..... Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 29 Carroll Avenue  
 (If rural, give LOCATION)  
World War I  
 2.(a) If veteran, name war..... ☒

## 3. (a) FULL NAME

JOHN L. MC KENNEY

## 3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Widowed  
 6.(b) Name of husband or wife..... ---  
 7. Birth date of deceased (mo., day, yr.)..... December 27, 1869 6.(c) If alive, give age..... years  
 8. AGE: Years..... 77 Months..... 9 Days..... 5 It less than one day..... hrs. min.

9. Birthplace..... Mass.  
 (Town, county, and state)  
 10. Usual occupation..... Retired  
 11. Industry or business.....

12. Name..... Unknown  
 13. Birthplace..... Unknown  
 14. Maiden name..... Unknown  
 15. Birthplace..... Unknown

16. Informant..... Hospital Records  
 Address..... VAH, Perry Point, Md.  
 17. Removal Date thereof..... 10-3-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National Cemetery  
 Location..... Washington, D.C.

18. Funeral director..... Bennings & Son  
 Address..... Havre de Grace, Md.

19. Oct - 3 19 47 John E. Dougherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 2 19 47 at 6:17P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 10 19 46 to Oct. 2 19 47  
 and that I last saw him alive on October 2 19 47

Immediate cause of death..... Uremia DURATION..... 10 days

Due to..... Nephrosclerosis Unknown

Due to.....

Other conditions..... Arteriosclerotic heart disease  
& Ulcerative colitis, non-specific. Unknown  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work? .....

23. SIGNATURE..... A. E. Trollinger  
A. E. TROLLINGER MD., Clin. Director  
 Address..... VAH, Perry Point, Md. Date signed..... 10-3-47

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OCT 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

08976

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

4. Sex.....  
 5. Color or race.....  
 6.(a) Single, married, widowed, or divorced.....

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....  
 6.(c) If alive, give age..... years

8. AGE:.....  
 Years..... Months..... Days.....  
 If less than one day..... hrs. .... min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal, which).....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him alive on.....

Immediate cause of death.....

.....

.....

Due to.....

Due to.....

Other conditions.....

.....

Major findings of operations.....

.....

.....

.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

.....

Address.....

Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
OCT 13 1947  
BUREAU OF

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08977

950

96

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... *Cecil*  
 City or town..... *Rising Sun Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... *6 yrs*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... *Md.* County..... *Cecil*  
 City or town..... *Rising Sun Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Florence May Montgomery*

## 3. (b) Social Security Number

4. Sex..... *F* 5. Color or race..... *White* 6.(a) Single, married, widowed, or divorced..... *Married*

6.(b) Name of husband or wife..... *Harry S. Montgomery*

7. Birth date of deceased (mo., day, yr.)..... *April 26 1878* 6.(c) If alive, give age..... *72* years

8. AGE: Years..... *69* Months..... *5* Days..... *20* If less than one day..... hrs. .... min.

9. Birthplace..... *Port Deposit Md.*  
 (Town, county, and state)

10. Usual occupation..... *Housewife*

## 11. Industry or business

12. Name..... *Samuel T. Harris*  
 13. Birthplace..... *Port Deposit, Md.*

14. Maiden name..... *Hannah Porter*  
 15. Birthplace..... *Port Deposit Md.*

16. Informant..... *Mrs. H. Ryan*  
 Address..... *Rising Sun Md.*

17. Burial..... *West Nottingham* Date thereof..... *Oct. 19, 1947*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium..... *Cecil, Md. Rural*  
 Location.....

18. Funeral director..... *W. A. Patterson & Son*  
 Address..... *Perryville, Md.*

19. Date rec'd by registrar..... *Oct. 17 1947* Registrar..... *Diana E. Dougherty*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *October 16 1947* at *10:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... *Chronic Hypertension and Cardiac Decompensation* DURATION

Due to..... *Chronic Coronary Sclerosis*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

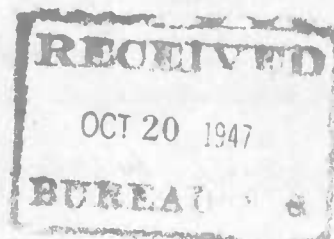
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

Medical Examiner..... *W. A. Patterson*

Address..... *Rising Sun Md.* Date signed..... *10-16-47*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08928

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Elk  
City or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Edward C. Nash7. Birth date of deceased (mo., day, yr.) May 26 - 1869

8. AGE:

Years 78Months 4Days 9

If less than one day

hrs.

min.

9. Birthplace Fairfax Vermont  
(Town, county, and state)10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name Samuel Stilson13. Birthplace Vermont14. Maiden name Samantha Kellogg15. Birthplace Vermont16. Informant Beatrice ThomasAddress North East - Md RD 117. Removal

(Burial, cremation, or removal. Which?)

Date thereof Oct 7 1947

(month) (day) (year)

Cemetery or crematory Fairfax cemeteryLocation St Albans Vermont18. Funeral director Joseph R. GrantAddress North East Maryland19. Oct 6

(Date rec'd by registrar)

1947

FR Fraser

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty ElkCity or town North East - Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 -

1947

at 9:10 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 4 -

1947

to Oct 5 -

1947

and that I last saw him alive on Oct 5 -

1947

Immediate cause of death Cerebral thrombosis

DURATION

about 12 hrsDue to Senile dementia

unknown

Due to Hypertension with

unknown

Other conditions general arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE V. H. McHugh

M. D. or other

Address Elkton - MdDate signed Oct 6 - 47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 9 1947  
BUREAU 7 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... **CECIL**  
 City or town..... **PERRY POINT, MARYLAND**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **19 yrs. 6 mos. 22 das.**  
 Hospital, institution, or street address where death occurred:  
**VAH, Perry Point, Maryland**  
 How long in hospital or institution?..... **About 21 years**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... **MARYLAND** County..... **BALTIMORE**  
 City or town..... **BALTIMORE**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **508 S. Streeper Street**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **World War I**

## 3. (a) FULL NAME

**JOSEPH RAPHAEL NOLAN**

## 3. (b) Social Security Number

4. Sex..... **M** 5. Color or race..... **W** 6.(a) Single, married, widowed, or divorced..... **Single**  
 6.(b) Name of husband or wife..... **---**  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... **December 28, 1893**  
 8. AGE: Years..... **53** Months..... **9** Days..... **4** If less than one day..... hrs. .... min.

9. Birthplace..... **Baltimore, Maryland**  
 (Town, county, and state)  
 10. Usual occupation..... **Switchboard Operator**  
 11. Industry or business.....

**FATHER**  
 12. Name..... **Edward R. Nolan**  
 13. Birthplace..... **Maryland**  
**MOTHER**  
 14. Maiden name..... **Beza Coyne Nolan**  
 15. Birthplace..... **Maryland**

16. Informant..... **Hospital Records**  
 Address..... **VAH, Perry Point, Md.**

17. **Removal** Date thereof..... **October 3, 1947**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... **Baltimore National Cemetery**  
 Location..... **Baltimore, Maryland**

18. Funeral director..... **Burial & Cremation**  
 Address..... **Havre de Grace, Maryland**

19. **Oct - 3** 19 **47** **Irvin E. Daugherty**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 2** 19 **47** at **6:15 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**March 10,** 19 **28**, to **Oct. 2** 19 **47**  
 and that I last saw him alive on **October 2** 19 **47**

Immediate cause of death..... **Bronchopneumonia, terminal** DURATION..... **5 days**

Due to..... **Encephalitis lethargica,**  
**Parkinsonian syndrome** ever **25 years**

Due to.....

Other conditions..... **Uremia** approx. **1 mo.**  
**Arteriosclerosis, generalized** Unknown  
 (Include pregnancy within 3 months of death)

Major findings of operations..... **---** Date of op. ....

Autopsy results..... **Confirms above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury..... Injured at work? .....

23. SIGNATURE..... **A.E. TROLLINGER, MD. Clin. Director**  
**VAH, Perry Point, Md.** Date signed..... **10-3-47**

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OCT 9 1947  
BUREAU 9 2

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

### 1. PLACE OF DEATH:

County Cecil  
City or town Elkton, Md  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Union  
Stay in hospital or inst. (yrs., or mos., or days) 5 days  
Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Cecil  
City or town Rural near Elkton Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. R.D. 3  
(If rural give LOCATION)  
2(c) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

Angelina Onizuk

### 3. (b) Social Security Number

4. Sex F. 5. Color or race Wh 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Andrew Onizuk

6. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1888

8. AGE: Years 59 Months 2 Days 29 If less than one day  
hrs. min.

9. Birthplace Poland  
(Town, county, and state)

10. Usual occupation at Home

### 11. Industry or business

12. Name Louis Tokar  
13. Birthplace Poland

14. Maiden name Hedwig Sminiaki  
15. Birthplace Poland

16. Informant Andrew Onizuk  
Address Elkton R.D. 3, Md

17. Burial Date thereof Oct 27/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Catholic  
Location Elkton, Md

18. Funeral director H. W. Pappin  
Address Elkton, Md

19. Oct 27 19 47 J. H. Frazer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 19 47 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 22 19 47 to October 25 19 47  
and that I last saw her alive on October 24 19 47.

Immediate cause of death distention of common bile duct  
Due to (Carcinoma of Pancreas)  
Due to

Other conditions

(Include pregnancy within 8 months of death)  
Major findings: none  
Of operations

Of autopsy

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Henry J. Davis M.D.  
Address Chesapeake City, Md M. D. or other  
Date signed 10/26/47

### DURATION

5 days

unknown

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 29 1947

BURIA 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

08981

96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Principles Furnace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Immediate  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County Wade  
 City or town Miami Beach  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6818 Bay Drive  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Milton Sanders Paer

## 3. (b) Social Security Number

109-16-8814

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 4 1895 6. (c) If alive, give age ..... years

8. AGE: Years 52 Months 6 Days 23 If less than one day ..... hrs. .... min.

9. Birthplace New York N.Y.  
 (Town, county, and state)

10. Usual occupation Secretary

11. Industry or business Shoe Business

12. Name Harriet Paer

13. Birthplace Russia

14. Maiden name Rebecca Sanders

15. Birthplace Russia

16. Informant Sam. Paer

Address 110-35 72 Rd Forest Hill Long Island

17. Removal (Burial, cremation, or removal, Which?) Removal Date thereof Oct. 28, 1947  
 (month) (day) (year)

Cemetery or crematory Riverside Memorial Chapel

Location Amsterdam Ave., & 76th St. New York

18. Funeral director W. A. Patterson & Son

Address Perryville, Md.

19. Oct. 28 19 47 Diana E. Dougherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1947 at 12:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death Fractured neck

Fractured left

Due to Arm

Lacerated scalp

Due to Contusion

Contusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10-27-47

Where did injury occur Principles Furnace Cecil Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) PRR tracks

Means of injury Trampled from train Injured at work? no

Medical Examiner

Pete Dockson M.D. for Cecil County

23. SIGNATURE Petering Sun Md. M. D. or other

Address 10827-47 Date signed

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OCT 30 1947

BUREAU 68

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08982

Reg. Diat. No. 95

## 1. PLACE OF DEATH:

County CecilCity or town Rising Sun  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County CecilCity or town Rising Sun  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Marshall Hartshorn Pierce

## 3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married8.(b) Name of husband or wife Mary Pierce6.(c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) April 13, 18678. AGE: Years 80 Months 6 Days 14 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Rising Sun, Cecil Co. Md.  
(Town, county, and state)10. Usual occupation Caretaker

11. Industry or business

12. Name William C. Pierce13. Birthplace Ireland14. Maiden name Sarah Rogers15. Birthplace md.16. Informant Mrs. Mary PierceAddress Rising Sun, Md.17. Burial Date thereof Oct. 31, 1947  
(Burial, cremation, or other. Which?) (month) (day) (year)Cemetery or crematory BrookviewLocation Rising Sun, Md.18. Funeral director E. TysonAddress Rising Sun, Md.19. Oct 29 47 Registrar Permit 10-29-47

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1947 at 5:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19\_\_\_\_, to 19\_\_\_\_

and that I last saw him alive on 19\_\_\_\_

Immediate cause of death

Chronic myocarditis  
& chronic  
hypertension

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE R. L. Dodson MD Medical ExaminerCecil County

M. D. or other

Address Rising Sun, Md. Date signed 10/25-47

RECEIVED

OCT 31 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

08983

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Christianaa Ricks

## 3. (b) Social Security Number

4. Sex.....  
 5. Color or race.....  
 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....  
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

9. Birthplace.....  
 (Town, county, and state)  
 10. Usual occupation.....

## 11. Industry or business

12. Name.....  
 13. Birthplace.....

14. Maiden name.....  
 15. Birthplace.....

16. Informant.....  
 Address.....

17. Burial..... Date thereof.....  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....  
 Location.....

18. Funeral director.....  
 Address.....

19. Oct 18 1947.....  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

Dilate of heart

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

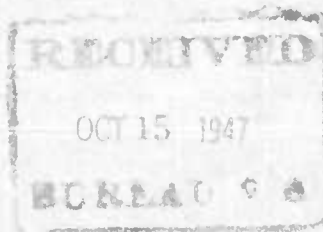
Means of injury..... Injured at work?

Medical Examiner.....

23. SIGNATURE..... Cecil County

M. D. or other

Address..... Date signed.....



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

592

08985

90

## 1. PLACE OF DEATH

County Cecil Registration Dist. No. 90  
 Village or City Warrick No.        St.        Ward         
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred 76 yrs.        mos.        ds. How long in U.S. if of foreign birth?        yrs.        mos.        ds.

## 2. FULL NAME

Henrietta Smith If U. S. Veteran, specify WAR         
 (a) Residence: No.        Warrick St.        Ward.         
 (Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Black</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Wm Smith</u>		
6. DATE OF BIRTH (month, day, and year) <u>April 18 - 1865</u>		
7. AGE <u>82</u>	Years <u>6</u>	Months <u>1</u>
Days <u>1</u>		If LESS than 1 day, <u>      </u> hrs. or <u>      </u> min.
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Home</u>		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.		
10. Date deceased last worked at this occupation (month and year)		

MOTHER	12. BIRTHPLACE (city or town) (State or country) <u>Wicomico Co - Maryland</u>
	13. NAME <u>Don't Know - No record</u>
FATHER	14. BIRTHPLACE (city or town) (State or country) <u>      </u>
	15. MAIDEN NAME <u>Gladys Perkins</u>
INFORMANT	16. BIRTHPLACE (city or town) (State or country) <u>      </u>
	17. INFORMANT (Address) <u>Katie Briscoe</u> <u>Warrick - Md.</u>
UNDERTAKER	18. BURIAL, CREMATION, OR REMOVAL Place <u>Cecil Cemetery</u> Date <u>10-22</u> , 19 <u>47</u>
	19. UNDERTAKER (Address) <u>Wm. H. Smith</u> <u>Middle Town - Del.</u>
20. FILED <u>Oct 22</u> , 19 <u>47</u> <u>Mrs. Harold W. Chappin</u> Registrar.	

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

October 19, 1947,  
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 22, 1941, to Oct 19, 1947  
 I last saw him alive on Sept 16, 1947; death is said to have occurred on the date stated above, at 9 P. m.  
 The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:  
Heart Disease & Sclerosis  
Hypertension

## Other Contributory Causes of importance:

Arthritis

Name of operation        Date of       

What test confirmed diagnosis?        Was there an autopsy?       

## 23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?        Date of injury       , 19      

Where did injury occur?       

(Specify city or town, county and State)  
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury       

Nature of injury       

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify       

(Signed) Dorsey W. Lewis M. D.

(Address) Middle Town - Del.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:		The principal cause of death and related causes of importance were as follows:	
	Date of onset		Date of onset
Arteriosclerosis	1915	Attack of epilepsy	1 week ago
Chronic interstitial nephritis	1921	Run over by street car	1 week ago
Cerebral hemorrhage	July 5, 1927	Peritonitis	3 days ago
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	May 1, 1923	Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

08986

93d

## 1. PLACE OF DEATH:

County..... **CECIL**  
 City or town..... **PERRY POINT, MARYLAND**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **23 days**  
 Hospital, institution, or street address where death occurred:  
**VAH, Perry Point, Maryland**  
 How long in hospital or institution?..... **Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... **MARYLAND** County..... **BALTIMORE**  
 City or town..... **BALTIMORE**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **208 Ridge Avenue**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **WW-I**

## 3. (a) FULL NAME

**REGINALD STEMBRIDGE, JR.**

## 3. (b) Social Security Number

**216-01-8885**

4. Sex..... **Male** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Married**  
 6. (b) Name of husband or wife..... **Alice Stembridge**  
 7. Birth date of deceased (mo., day, yr.)..... **May 20, 1892**  
 6. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	If less than one day
	<b>55</b>	<b>4</b>	<b>15</b>	..... hrs. .... min.

8. Birthplace..... **Cheshire, England**  
 (Town, county, and state)

10. Usual occupation..... **Salesman**

11. Industry or business.....

FATHER 12. Name..... **Unknown**  
 13. Birthplace..... **Unknown**

MOTHER 14. Maiden name..... **Unknown**  
 15. Birthplace..... **Unknown**

16. Informant..... **Hospital Records**  
 Address..... **VAH, Perry Point, Md.**

17. **Removal** Date thereof..... **October 16, 1947**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... **Prospect Hills**  
 Location..... **Towson, Maryland**

18. Funeral director..... **John Burns Sons**  
 Address..... **Towson, Maryland**

19. **Oct. 16, 1947** **Irene E. Hughes**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 15** 19 **47**, at **3:15 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**September 22** 19 **47**, to **October 15** 19 **47**  
 and that I last saw him alive on **October 15** 19 **47**

Immediate cause of death..... **Chronic myocarditis and myocardial degeneration** DURATION..... **Unknown**

Due to..... **Coronary arteriosclerosis** Unknown

Due to.....

Other conditions..... **Diffuse fibronous pleurisy; generalized arteriosclerosis** Unknown  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... **Confirms above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... **V. J. COVALESKY, M.D., Act. Clin. Director**  
 Address..... **VAH, Perry Point, Md.** Date signed..... **10-16-47**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 17 1947

BUREAU 98

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County ElktonCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Union HospitalHow long in hospital or institution? 3 days

## 3. (a) FULL NAME

Rachael H Welch4. Sex female5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Patrick Welch6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) About 18838. AGE: Years about 64 Months — Days — If less than one dayhrs. — min. —9. Birthplace North East, Md  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name no13. Birthplace no14. Maiden name no15. Birthplace no16. Informant Hospital Records

Address

17. Buried Date thereof Oct 14-1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MethodistLocation North East, Md18. Funeral director Joseph R. GaultAddress North East, Md19. Oct 13 19 47 FR Trager  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ElktonCity or town North East  
(If outside city or town limits, write RURAL and give nearest town)Street No. —  
(If rural, give LOCATION)2. (c) If veteran, name war —

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct 10 1947 at 4:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 1947 to Oct 10 1947and that I last saw him alive on Oct 9 1947Immediate cause of death Diabetic coma DURATION 4 daysDue to Diabetes mellitus unknownDue to Chronic undisturbed nephritis unknownOther conditions Ischemic life

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. F. M. Knight M.D. M. D. or otherAddress Elkton, Md Date signed 10/10/47

RECEIVED  
OCT 15 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

Reg. Dist. No. 96

68988

## 1. PLACE OF DEATH:

County Cecil  
 City or town VAH. Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Year, 8 Mos., 7 days  
 Hospital, institution, or street address where death occurred:  
Veterans Hospital, Perry Point, Md.  
 How long in hospital or institution? 1 Yr., 8 Mos., 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City City  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2823 Lafayette Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War 1 ✓

## 3. (a) FULL NAME

James WILLIAMS

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 5, 1887 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 60 Months 7 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md., Baltimore County  
 (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business

12. Name James Williams Sr.13. Birthplace New York14. Maiden name Adele Laplatte15. Birthplace Canada16. Informant Hospital Records

Address

17. Removal Date thereof Oct 28, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Flynn & Fleming Cathedral Cem.Location Baltimore, Md.18. Funeral director Flynn & FlemingAddress 1426 Light St., Balto., Md.

19. Oct 28 19 47 James E. Laughlin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 19 47 at 3:55P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Coronary occlusion DURATION 10 Min.Due to coronary sclerosis Unk.

Due to \_\_\_\_\_

Other conditions Arteriosclerosis, generalized, coronary sclerosis, diverticulitis of ileum adenoma, adrenal, right. Nephrosclerosis  
 (Include pregnancy within 1 month of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results See above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Blair Dodson Medical Examiner  
Blair Dodson for Cecil County  
 M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 10/27-47

RECEIVED

OCT 31 1947

BUREAU 6 8